ì ′		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155029	A. BUILDING ————————————————————————————————————			COMPLI	
		100028	B. WIN			00/07/2	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COMMUI	NITY NURSING AN	D REHABILITATION CENTER			APOLIS, IN 46218		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG F0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	ì	DATE
F0000							
	This visit was for	r a Recertification and	F00	00			
	State Licensure S						
	Survey dates: Ju	ne 4, 5, 6, 7, 2012					
	Facility number:	000012					
	Provider number	: 155029					
	AIM number:	100274900					
	Survey team:						
	Connie Landman						
	Diana Zgonc RN						
	Lora Brettnacher	RN					
	Christi Davidson	RN					
	Congue had type:						
	Census bed type: SNF/NF: 104						
	Total: 104						
	10tai. 10 ²	4					
	Census payor typ	oe:					
	Medicare: 16						
	Medicaid: 74						
		4					
	These deficiencie	es also reflect State					
	findings in accor	dance with 410 IAC					
	16.2.						
		ompleted 6/12/12					
	Cathy Emswiller	RN					
LABORATOR	V DIDECTORIC OR PROJ	JIDED/SUBBUTED DEDDESENTATIVE'S SIG	I TILDI		TITI E		(Y6) DATE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

VPZ111

Facility ID:

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218				
NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VPZ111

Facility ID: 000012

If continuation sheet

Page 2 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155029	B. WING		06/07/2012		
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER						
COMMUN	NITY NURSING AN	D REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG			TAG	DEFICIENCY)	DATE		
F0279 SS=D	483.20(d), 483.2 DEVELOP COM PLANS A facility must us assessment to de resident's comprended to the facility must care plan for each measurable object meet a resident's mental and psychidentified in the comprended to the furnisher resident's highes mental, and psychiat would other §483.25 but are resident's exercis including the right §483.10(b)(4). Based on recor interview, the formal services and the formal services and the factorial services are services and the factorial services are services and the factorial services and the factorial services are services and the factorial s	o(k)(1) PREHENSIVE CARE se the results of the evelop, review and revise the ehensive plan of care. develop a comprehensive sh resident that includes ectives and timetables to se medical, nursing, and hosocial needs that are comprehensive assessment. set describe the services that ed to attain or maintain the est practicable physical, chosocial well-being as 483.25; and any services wise be required under not provided due to the se of rights under §483.10, at to refuse treatment under	F0279	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set	of 07/02/2012 ot		
	timetables to m	urable objectives and neet each resident's is for 1 of 40 residents		forth in the statement of deficiencies, or of any violation of regulation. This provider			
	who met the criteria for care plans (Resident #74).			respectfully requests that this 2567 Plan of Correction be considered the Letter of Credit Allegation of Compliance and	ple		
	Findings includ	e:		requests a Post Survey Review on or after 7/2/12 F279 Develo	р		
	Resident #74 w	4's record was 6/2012 at 9:30 A.M. vas admitted on had current diagnoses		the practice of this provider to ensure that every resident has comprehensive care plan that includes measurable objective	а		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VPZ111

Facility ID: 000012

If continuation sheet

Page 3 of 7

		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LDING	00	COMPLETED		
		155029	B. WIN			06/07/2	2012	
		<u> </u>		_	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER				16TH ST			
		D REHABILITATION CENTER		INDIAN	APOLIS, IN 46218			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX	`	CY MUST BE PERCEDED BY FULL	CROSS-REFERENCED TO THE APPI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	RIATE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE	
	which included	but were not limited to			and timetables to meet a			
	paranoid schize	ophrenia, diabetes			resident's medical, nursing, ar			
	mellitus, history	of a cerebral vascular			mental and psychological nee	as		
	accident (Strok	e), history of urinary			that are identified in the comprehensive assessment.			
	•	cystitis, and seizure			What corrective action(s) wil	.		
	disorder.	ojosiso, aria ooizaro			be taken for those residents	.		
	uisoiuei.				found to have been affected	_{bv}		
	A a	aiamla andan ara tha			the deficient practice? At the	- 1		
		cian's order on the			time the deficiency was identif			
		112 recaps indicated			a care plan for resident #74 w			
	Resident #74 w	vas taking Fluphenaz			put into place addressing			
	(anti-psychotic	medication) 25 MG/ML			anti-psychotic medication usag	ge		
	(milligrams/Mill	iliters) injection			and addressing bowel and			
	,	and Fluphenazine 2.5			bladder incontinence. A full ho	ouse		
		aily for the diagnoses			audit on ADL coding for			
		•			continence will be completed I	-		
	of schizophreni	d.			Minimal Data Sets Coordinato			
					ensure that those residents wi incontinent episodes have	uı		
		record lacked a care			appropriate care plan in place	Δ		
	plan addressing	g anti-psychotic			full house audit will be comple			
	medication usa	ge.			by the Social Services Directo			
					designee on those residents			
	During an inter	view on 6/7/2012 at			receiving anti-psychotic			
		e DON (Director of			medication to ensure that			
	1	ted he would expect			appropriate care plan is in plac	ce.		
	J ,	•			The Minimal Data Sets			
		lents on anti-psychotic			Coordinator or designee will			
		have a care-plan			educate facility aides and nurs	ses		
	_	potential side affects.			on resident ADL coding in regards to continence, toileting	,		
	He further indic	cated if this resident did			and assistance. This will occu	_		
	not have one h	e would have one			7/27/12. The Minimal Data Se			
	today.				Coordinator will educate the	`		
					Social Services Director and			
	On 6/7/2012 at	10:30 A.M. the DON			designee on Care Plan			
					Development in regards to			
	provided a care	•			anti-psychotic medication usag	ge.		
		ssing Resident #74's			This will occur on 7/21/12. Ho	w		
	' '	edication. Prior to this			will you identify other reside	nts		
	date there had not been a care plan				having the potential to be			

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DINC	00	COMPLETED		
		155029		LDING		06/07/	06/07/2012	
			B. WIN		ADDRESS CITY STATE ZID CODE			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
					16TH ST			
COMMUI	NITY NURSING AN	ID REHABILITATION CENTER		INDIAN	APOLIS, IN 46218			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	"-	DATE	
	for this residen	t regarding			affected by the same deficien	nt		
	psychotropic m	-			practice and what corrective			
		icalcation asc.			action will be taken? All			
	Daviess of a sie	unificant change MDC			residents who reside in the fac	cility		
	· ·	gnificant change MDS			have the potential to be affect	ed		
	l ,	set-assessment tool)			by this alleged deficient praction	ce.		
	dated 1/25/201	2 indicated Resident			The Minimal Data Sets			
	#74 had a decl	line in urinary			Coordinator or designee will			
	incontinence a	nd was occasionally			educate facility aides and nurs	ses		
		esident #74 had			on resident ADL coding in regards to continence, toileting	,		
		atric problems, urinary			and assistance. This will occu			
	1	ed for assistance to the			7/27/12. The Minimal Data Se			
	, ,				Coordinator will educate the	١		
		ry incontinence would			Social Services Director and			
	· ·	ed. Review of a			designee on Care Plan			
	quarterly MDS	indicated Resident #74			Development in regards to			
	was occasiona	Ily incontinent and not			anti-psychotic medication usag	ge.		
	on a toileting p	rogram. Resident #74			This will occur on 7/21/12. Wh	at		
		d assistance of one			measures will be put into pla	ce		
	staff for toiletin				or what systemic changes w	ill		
		9.			you make to ensure that the			
	Desident #741e	record failed to			deficient practice does not			
		record failed to			recur? To ensure compliance			
		plan for urinary			the MDS/Designee is respons			
	incontinence.				for the completion of the Blade			
					and Bowel elimination CQI too			
	During an inter	view on 6/6/2012 at			weekly times 4 weeks, bi-mon times 2 months, and then	uny		
	4:00 P.M The	Administrator was			quarterly until continued			
	· ·	ent #74 had a care plan			compliance is maintained for 2	,		
	which address	•			consecutive quarters. The res			
	incontinence.	ed dililary			of these audits will be reviewe			
	incontinence.				by the CQI committee oversee	en		
					by the ED. If threshold of 95%			
		t 10:15 A.M., the DON			not achieved an action plan w	ill		
	(Director of Nu	rsing) provided a care			be developed to ensure			
	plan which indi	cated Resident #74			compliance. To ensure	.		
	•	Illy incontinent due to a			compliance, the DNS/Designe			
		oral vascular accident			responsible for the completion			
					the Anti-Psychotic Medication			
	(stroke) and chronic cystitis. This		1		Use CQI tool weekly x 4,			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE		
THE TENT	or condition	155029	A. BUILDING			/2012
		100020	B. WING	ADDRESS CHARLES TO THE		
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CO	DDE	
COMMU	MITY NII IDQINIC AN	ID REHABILITATION CENTER		E 16TH ST NAPOLIS, IN 46218		
				1/AI OLIO, IIN 40210		•
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AR DEFICIENCY)	OULD BE PPROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG			DATE
	•	dated created on		bi-monthly times 2 mon then quarterly until conf		
		r to this date there was		compliance is maintaine		
	•	which addressed		consecutive quarters. T		
	Resident #74's	urinary incontinence.		of these audits will be re		
				by the CQI committee of		
	3.1-35(a)			by the ED. If threshold		
				not achieved an action be developed to ensure	•	
				compliance. To ensure		
				compliance, the DNS/D		
				responsible for the com	-	
				the Care Plan Review (
				weekly x 4, bi-monthly t		
				months, and then quart	•	
				continued compliance is maintained for 2 consecutive.		
				quarters. The results of		
				audits will be reviewed		
				committee overseen by	•	
				threshold of 95% is not		
				an action plan will be de		
				to ensure compliance. I		
				corrective action(s) wi		
				deficient practice will		
				i.e. what quality assura	-	
				program will be put in		
				Bladder and Bowel elim		
				CQI will be reviewed m		
				the CQI Committee ove	•	
				the ED. If threshold of 9 achieved an action plan		
				developed to ensure co		
				Anti-Psychotic Medicati		
				CQI will be reviewed m		
				the CQI Committee over	-	
				the ED. If threshold of 9		
				achieved an action plan		
				developed to ensure co	-	
				reviewed monthly by th		
			1	1	·	1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VPZ111

Facility ID: 000012

If continuation sheet

Page 6 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED					
		155029	B. WING		06/07/2012			
NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(X5) E COMPLETION DATE	1			
	*			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPED DEFICIENCY) Committee overseen by the threshold of 95% is not achie an action plan will be develor to ensure compliance. Deficin this practice will result in disciplinary action up to and including termination of the responsible employee. Date Compliance 7/2/12	ED. If eved ped iency			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VPZ111

Facility ID: 000012

If continuation sheet

Page 7 of 7